Senate

General Assembly

File No. 451

February Session, 2016

Substitute Senate Bill No. 433

Senate, April 4, 2016

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING STANDARDS AND REQUIREMENTS FOR HEALTH CARRIERS' PROVIDER NETWORKS AND CONTRACTS BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) **[**Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.**]** As used in this section:

(1) "Authorized representative" means (A) an individual to whom a covered person has given express written consent to represent the covered person, (B) an individual authorized by law to provide substituted consent for a covered person, or (C) the covered person's treating health care provider when the covered person is unable to provide consent or a family member of the covered person;

(2) "Covered benefit" or "benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) "Covered person" has the same meaning as provided in section 38a-591a;

(4) "Essential community provider" means a health care provider or facility that (A) serves predominantly low-income, medically underserved individuals and includes covered entities, as defined in 42 USC 256b, as amended from time to time, or (B) is described in 42 USC 1396r-8(c)(1)(D)(i)(IV), as amended from time to time;

(5) "Facility" has the same meaning as provided in section 38a-591a;

(6) "Health benefit plan" has the same meaning as provided in section 38a-591a;

(7) "Health care provider" has the same meaning as provided in section 38a-477aa;

(8) "Health care services" has the same meaning as provided in section 38a-478;

(9) "Health carrier" has the same meaning as provided in section 38a-591a;

(10) "Intermediary" means a person, as defined in section 38a-1, authorized to negotiate and execute health care provider contracts with health carriers on behalf of health care providers or a network;

(11) "Network" means the group or groups of participating

providers providing health care services under a network plan;

(12) "Network plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers or facilities that are managed, owned, under contract with or employed by the health carrier;

(13) "Participating provider" means a health care provider or a facility that, under a contract with a health carrier or such health carrier's contractor or subcontractor, has agreed to provide health care services to such health carrier's covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles;

(14) "Primary care" means health care services for a range of common physical, mental or behavioral health conditions, provided by a health care provider;

(15) "Primary care provider" means a participating health care provider designated by a health carrier to supervise, coordinate or provide initial health care services or continuing health care services to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services provided to the covered person;

(16) "Specialist" means a health care provider who (A) focuses on a specific area of physical, mental or behavioral health or a specific group of patients, and (B) has successfully completed required training and is recognized by this state to provide specialty care. "Specialist" includes a subspecialist who has additional training and recognition beyond that required for a specialist;

(17) "Specialty care" means advanced medically necessary care and treatment of specific physical, mental or behavioral health conditions, or those conditions that may manifest in particular ages or subpopulations, that are provided by a specialist in coordination with

a health care provider;

(18) "Telemedicine" or "telehealth" has the same meaning as "telehealth", as defined in section 19a-906; and

(19) "Tiered network" means a network that identifies and groups some or all types of health care providers and facilities into specific groups to which different participating provider reimbursement, covered person cost-sharing or participating provider access requirements, or any combination thereof, apply for the same health care services.

(b) The provisions of this section and sections 2 and 3 of this act shall apply to all health carriers that deliver, issue for delivery, renew, amend or continue a network plan in this state.

(c) (1) (A) Each health carrier shall establish and maintain a network that includes a sufficient number and appropriate types of participating providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered benefits will be accessible to all such health carrier's covered persons without unreasonable travel or delay.

(B) Each health carrier shall assure that all covered persons have access to emergency services, as defined in section 38a-477aa, twenty-four hours a day, seven days a week.

(2) The Insurance Commissioner shall determine the sufficiency of a health carrier's network in accordance with the provisions of this subsection and may establish sufficiency by reference to any reasonable criteria, including, but not limited to, (A) the ratio of participating providers to covered persons by specialty, (B) the ratio of primary care providers to covered persons, (C) the geographic accessibility of participating providers, (D) the geographic variation and dispersion of the state's population, (E) the wait times for appointments with participating providers, (F) the hours of operation of participating providers, (G) the ability of the network to meet the

needs of covered persons that may include low-income individuals, children and adults with serious, chronic or complex conditions or physical or mental disabilities or individuals with limited English proficiency, (H) the availability of other health care delivery system options, such as telemedicine, telehealth, centers of excellence and mobile clinics, (I) the volume of technological and specialty care services available to serve the needs of covered persons who require technologically advanced or specialty care services, (J) the extent to which participating health care providers are accepting new patients, (K) the degree to which (i) participating health care providers are authorized to admit patients to hospitals participating in the network, and (ii) hospital-based health care providers are participating providers, and (L) the regionalization of specialty care.

(d) (1) Each health carrier shall establish and maintain a process to ensure that a covered person receives a covered benefit at an in-network level, including an in-network level of cost-sharing, from a nonparticipating provider, or shall make other arrangements acceptable to the commissioner, when:

(A) The health carrier has a sufficient network but does not have (i) a type of participating provider available to provide the covered benefit to the covered person, or (ii) a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) Each health carrier shall disclose to a covered person the process to request a covered benefit from a nonparticipating provider, as provided under subdivision (1) of this subsection, when:

(A) The covered person is diagnosed with a condition or disease that requires specialty care; and

(B) The health carrier (i) does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease, or (ii) cannot provide reasonable access to a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall deem the health care services such covered person receives from a nonparticipating provider pursuant to subdivision (2) of this subsection to be health care services provided by a participating provider, including counting the covered person's cost-sharing for such health care services toward the maximum out-of-pocket expenses limit applicable to health care services received from participating providers under the health benefit plan.

(4) The health carrier shall ensure that the processes described under subdivisions (1) and (2) of this subsection address a covered person's request to obtain a covered benefit from a nonparticipating provider in a timely fashion appropriate to the covered person's condition. The time frames for such processes shall mirror those set forth in subsections (e) and (f) of section 38a-591g for external reviews of adverse determinations and final adverse determinations.

(5) The health carrier shall document all requests from its covered persons to obtain a covered benefit from a nonparticipating provider pursuant to this subsection and shall provide such documentation to the commissioner upon request.

(6) No health carrier shall use the process described in subdivisions (1) and (2) of this subsection as a substitute for establishing and maintaining a sufficient network as required under subsection (b) of this section. No covered person shall use such process to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this subsection shall be construed to affect any rights

or remedies available to a covered person under sections 38a-591a to 38a-591g, inclusive, or federal law relating to internal or external claims grievance and appeals processes.

(e) (1) Each health carrier shall:

(A) Maintain adequate arrangements to assure that such health carrier's covered persons have reasonable access to participating providers located near such covered persons' places of residence or employment. In determining whether a health carrier has complied with this subparagraph, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration;

(B) Monitor on an ongoing basis the ability, clinical capacity and legal authority of its participating providers to provide all covered benefits to its covered persons;

(C) Establish and maintain procedures by which a participating provider will be notified on an ongoing basis of the specific covered health care services for which such participating provider will be responsible, including any limitations on or conditions of such services;

(D) Ensure that participating providers provide covered benefits to all covered persons without regard to a covered person's enrollment in a network plan as a private purchaser of such network plan or as a participant in a publicly financed health care program, except that nothing in this subparagraph shall be construed to apply to circumstances when a participating provider should not provide services due to limitations arising from lack of training, experience or skill or license restrictions;

(E) Notify participating providers of their obligations, if any, (i) to collect applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan, and (ii) to notify covered persons of such covered persons' financial

obligations for noncovered benefits;

(F) Establish and maintain procedures by which a participating provider may determine in a timely manner at the time benefits are provided whether an individual is a covered person or is within a grace period for payment of premium during which such health carrier may hold a claim for health care services pending receipt of payment of premium by such health carrier;

(G) Timely notify a health care provider or facility, when such health carrier has included such health care provider or facility as a participating provider for any of such health carrier's health benefit plans, of such health care provider's or facility's network participation status;

(H) Notify participating providers of the participating provider's responsibilities with respect to such health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance and appeals processes, date reporting requirements, reporting requirements for timely notice of changes in practice such as discontinuance of accepting new patients, confidentiality requirements, any applicable federal or state programs and obtaining necessary approval of referrals to nonparticipating providers; and

(I) Establish and maintain procedures for the resolution of administrative, payment or other disputes between the health carrier and a participating provider.

(2) No health carrier shall:

(A) Offer or provide an inducement to a participating provider that would encourage or otherwise incentivize a participating provider to provide less than medically necessary health care services to a covered person;

(B) Prohibit a participating provider from (i) discussing any specific

or all treatment options with covered persons, irrespective of such health carrier's position on such treatment options, or (ii) advocating on behalf of covered persons within the utilization review or grievance and appeals processes established by such health carrier or a person contracting with such health carrier or in accordance with any rights or remedies available to covered persons under sections 38a-591a to 38a-591g, inclusive, or federal law relating to internal or external claims grievance and appeals processes; or

(C) Penalize a participating provider because such participating provider reports in good faith to state or federal authorities any act or practice by such health carrier that jeopardizes patient health or welfare.

(f) (1) Each health carrier shall develop standards, to be used by such health carrier and its intermediaries, for selecting and tiering, as applicable, participating providers and each health care provider specialty.

(2) No health carrier shall establish selection or tiering criteria in a manner that would (A) allow the health carrier to discriminate against high-risk populations by excluding or tiering participating providers because they are located in a geographic area that contains populations or participating providers that present a risk of higher-than-average claims, losses or health care services utilization, or (B) exclude participating providers because they treat or specialize in treating populations that present a risk of higher-than-average claims, losses or health care services utilization. Nothing in this subdivision shall be construed to prohibit a health carrier from declining to select a health care provider or facility for participation in such health carrier's network who fails to meet legitimate selection criteria established by such health carrier.

(3) No health carrier shall establish selection criteria that would allow the health carrier to discriminate, with respect to participation in a network plan, against any health care provider who is acting within the scope of such health care provider's license or certification under

state law. Nothing in this subdivision shall be construed to require a health carrier to contract with any health care provider or facility willing to abide by the terms and conditions for participation established by such health carrier.

(4) Each health carrier shall make the standards required under subdivision (1) of this subsection available to the commissioner for review and shall make available to the public a plain language description of such standards.

(5) Nothing in this subsection shall require a health carrier, its intermediaries or health care provider networks with which such health carrier or intermediary contracts to (A) employ specific health care providers acting within the scope of such health care providers' license or certification under state law who meet such health carrier's selection criteria, or (B) contract with or retain more health care providers acting within the scope of such health care providers' license or certification under state law than are necessary to maintain a sufficient network.

(g) (1) (A) A health carrier and participating provider shall provide at least sixty days' written notice to each other before the health carrier removes a participating provider from the network or the participating provider leaves the network. Each participating provider that receives a notice of removal or issues a departure notice shall provide to the health carrier a list of such participating provider's patients who are covered persons under a network plan of such health carrier.

(B) A health carrier shall make a good faith effort to provide written notice, not later than thirty days after the health carrier receives or issues a written notice under subparagraph (A) of this subdivision, to all covered persons who are patients being treated on a regular basis by or at the participating provider being removed from or leaving the network, irrespective of whether such removal or departure is for cause.

(C) If the participating provider being removed from or leaving the

network is a primary care provider, the health carrier shall provide written notice to all covered persons who are patients of such primary care provider.

(2) (A) For the purposes of this subdivision:

(i) "Active course of treatment" means (I) an ongoing course of treatment for a life-threatening condition, (II) an ongoing course of treatment for a serious acute condition, (III) care provided during the second or third trimester of pregnancy, or (IV) an ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes;

(ii) "Life-threatening condition" means a disease or condition for which the likelihood of death is probable unless the course of such disease or condition is interrupted;

(iii) "Serious acute condition" means a disease or condition that requires complex ongoing care such as chemotherapy, radiation therapy or postoperative visits, which the covered person is currently receiving; and

(iv) "Treating provider" means a covered person's treating health care provider or a facility at which a covered person is receiving treatment, that is removed from or leaves a health carrier's network pursuant to subdivision (1) of this subsection.

(B) (i) Each health carrier shall establish and maintain reasonable procedures to transition a covered person, who is in an active course of treatment with a participating health care provider or at a participating facility that becomes a treating provider, to another participating provider in a manner that provides for continuity of care. A covered person shall be deemed to be in an active course of treatment if such covered person has been treated on a regular basis by such participating health care provider or at such participating facility.

(ii) In addition to the notice required under subdivision (1) of this subsection, the health carrier shall provide to such covered person (I) a list of available participating providers in the same geographic area as such covered person who are of the same health care provider or facility type, and (II) the procedures for how such covered person may request continuity of care as set forth in this subparagraph.

(iii) Such procedures shall provide that:

(I) Any request for a continuity of care period shall be made by the covered person or the covered person's authorized representative;

(II) A request for a continuity of care period, made by a covered person who meets the requirements under subparagraph (B)(i) of this subdivision or such covered person's authorized representative and whose treating provider was not removed from or did not leave the network for cause, shall be reviewed by the health carrier's medical director after consultation with such treating provider; and

(III) For a covered person who is in the second or third trimester of pregnancy, the continuity of care period shall extend through the postpartum period.

(iv) The continuity of care period for a covered person who is undergoing an active course of treatment shall extend to the earliest of the following: (I) Termination of the course of treatment by the covered person or the treating provider; (II) ninety days after the date the participating provider is removed from or leaves the network, unless the health carrier's medical director determines that a longer period is necessary; (III) the date that care is successfully transitioned to another participating provider; (IV) the date benefit limitations under the health benefit plan are met or exceeded; or (V) the date the health carrier determines care is no longer medically necessary.

(v) The health carrier shall only grant a continuity of care period as provided under subparagraph (B)(iv) of this subdivision if the treating provider agrees, in writing, (I) to accept the same payment from such

health carrier and abide by the same terms and conditions as provided in the contract between such health carrier and treating provider when such treating provider was a participating provider, and (II) not to seek any payment from the covered person for any amount for which such covered person would not have been responsible if the treating provider was still a participating provider.

(h) (1) (A) Beginning January 1, 2017, a health carrier shall file with the commissioner for review each existing network as of said date and an access plan for each such network.

(B) For each new network a health carrier intends to offer after January 1, 2017, such health carrier shall file with the commissioner for review, within thirty days prior to the date such health carrier will offer such new network, the new network and an access plan for such new network.

(C) A health carrier shall notify the commissioner of any material change to an existing network not later than fifteen business days after such change and shall file with the commissioner an update to such existing network not later than thirty days after such material change. For the purposes of this subparagraph, "material change" means (i) a change of twenty-five per cent or more in the participating providers in a health carrier's network or the type of participating providers available in a health carrier's network to provide health care services or specialty care to covered persons, or (ii) any change that renders a health carrier's network noncompliant with one or more network adequacy standards, such as (I) a significant reduction in the number of primary care or specialty care providers available in the network, (II) a reduction in a specific type of participating provider such that a specific covered benefit is no longer available to covered persons, (III) a change to a tiered, multitiered, layered or multilevel network plan structure, or (IV) a change in inclusion of a major health system, as defined in section 19-508c, that causes a network to be significantly different from what a covered person initially purchased.

(2) Each access plan required under subdivision (1) of this

subsection shall be in a form and manner prescribed by the commissioner and shall contain descriptions of at least the following:

(A) The health carrier's network, including how the use of telemedicine, telehealth or other technology may be used to meet network access standards, if applicable;

(B) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(C) The health carrier's procedures for monitoring and assuring on an ongoing basis the sufficiency of its network to meet the health care needs of the populations that enroll in its network plans;

(D) The factors used by the health carrier to build its network, including a description of the network and the criteria used to select and tier health care providers and facilities;

(E) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex conditions. Such description shall include the health carrier's efforts, when appropriate, to include various types of essential community providers in its network;

(F) The health carrier's methods for assessing the health care needs of covered persons and covered persons' satisfaction with the health care services provided;

(G) The health carrier's method of informing covered persons of the network plan's covered benefits, including, but not limited to, (i) the network plan's grievance and appeals processes, (ii) the network plan's process for covered persons to choose or change participating providers in the network plan, (iii) the health carrier's process for updating its participating provider directories for each of its network plans; (iv) a statement of the health care services offered by the network plan, including those health care services offered through the

preventive care benefit, if applicable; and (v) the network plan's procedures for covering and approving emergency, urgent and specialty care, if applicable;

(H) The health carrier's system for ensuring the coordination and continuity of care for covered persons (i) referred to specialty physicians, or (ii) using ancillary services, including, but not limited to, social services and other community resources and for ensuring appropriate discharge planning for covered persons using such ancillary services;

(I) The health carrier's process for enabling covered persons to change their designation of a primary care provider, if applicable;

(J) The health carrier's proposed plan for providing continuity of care to covered persons in the event of contract termination between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. Such description shall explain how covered persons will be notified of such contract termination, insolvency or other cessation of operations and transitioned to other participating providers in a timely manner;

(K) The health carrier's process for monitoring access to specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology and laboratory services at such health carrier's participating hospitals;

(L) The health carrier's efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes for network plans that such health carrier has designed to include health care providers and facilities that provide high quality of care and health outcomes;

(M) The health carrier's accreditation by the National Committee for Quality Assurance that such health carrier meets said committee's network adequacy requirements or by URAC that such health carrier

meets URAC's provider network access and availability standards; and

(N) Any other information required by the commissioner to determine the health carrier's compliance with this section.

(3) A health carrier shall post each access plan on its Internet web site and make such access plan available at the health carrier's business premises in this state and to any person upon request, except that such health carrier may exclude from such posting or publicly available access plan any information such health carrier deems to be proprietary information that, if disclosed, would cause the health carrier's competitors to obtain valuable business information. A health carrier may request the commissioner not to disclose such information under section 1-210.

(i) (1) If the commissioner determines that (A) a health carrier has not contracted with a sufficient number of participating providers to assure that its covered persons have accessible health care services in a geographic area, (B) a health carrier's access plan does not assure reasonable access to covered benefits, (C) a health carrier has entered into a contract that does not conform to the requirements of this section or section 2 of this act, or (D) a health carrier has not complied with a provision of this section or section 2 or 3 of this act, the health carrier shall modify its access plan or implement a corrective action plan, as appropriate, and as directed by the commissioner. The commissioner may take any other action authorized under this title to bring a health carrier into compliance with this section and sections 2 and 3 of this act.

(2) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section and sections 2 and 3 of this act.

Sec. 2. (NEW) (*Effective January 1, 2017*) (a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a of the general statutes, (2) "health care provider" has the same meaning as provided in subsection

(a) of section 38a-477aa of the general statutes, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f of the general statutes, as amended by this act.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons

without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in subdivision (2) of subsection (g) of section 38a-472f of the general statutes, as amended by this act, or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled;

(C) (i) A provision that requires the participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons, and (ii) a statement that such participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records; and

(D) Definitions of what is considered timely notice and a material change for the purposes of subdivision (2) of subsection (c) of this section.

(2) The contract terms set forth in subparagraphs (A) and (B) of subdivision (1) of this subsection shall (A) be construed in favor of the covered person, (B) survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health carrier, and (C) supersede any oral or written agreement between a health care provider and a covered person or a covered person's authorized representative that is contrary to or inconsistent with the requirements set forth in subdivision (1) of this subsection.

(3) No contract subject to this subsection shall include any provision that conflicts with the provisions contained in the network plan or required under this section, section 38a-472f of the general statutes, as amended by this act, or section 3 of this act.

(4) No health carrier or participating provider that is a party to a contract under this subsection shall assign or delegate any right or responsibility required under such contract without the prior written consent of the other party.

(c) (1) At the time a contract subject to subsection (b) of this section is signed, the health carrier or such health carrier's intermediary shall disclose to a participating provider all provisions and other documents incorporated by reference in such contract.

(2) While such contract is in force, the health carrier shall timely notify a participating provider of any change to such provisions or other documents specified under subdivision (1) of this subsection that will result in a material change to such contract.

(d) (1) (A) Each contract between a health carrier and an intermediary entered into, renewed or amended on or after January 1, 2017, shall satisfy the requirements of this subsection.

(B) Each intermediary and participating providers with whom such intermediary contracts shall comply with the applicable requirements of this subsection.

(2) No health carrier shall assign or delegate to an intermediary such health carrier's responsibilities to monitor the offering of covered benefits to covered persons. To the extent a health carrier assigns or delegates to an intermediary other responsibilities, such health carrier shall retain full responsibility for such intermediary's compliance with the requirements of this section.

(3) A health carrier shall have the right to approve or disapprove the participation status of a health care provider or facility in such health carrier's own or a contracted network that is subcontracted for the

purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain at its principal place of business in this state copies of all intermediary subcontracts or ensure that such health carrier has access to all such subcontracts. Such health carrier shall have the right, upon twenty days' prior written notice, to make copies of any intermediary subcontracts to facilitate regulatory review.

(5) (A) Each intermediary shall, if applicable, (i) transmit to the health carrier documentation of health care services utilization and claims paid, and (ii) maintain at its principal place of business in this state, for a period of time prescribed by the commissioner, the books, records, financial information and documentation of health care services received by covered persons, in a manner that facilitates regulatory review, and shall allow the commissioner access to such books, records, financial information and documentation as necessary for the commissioner to determine compliance with this section and section 38a-472f of the general statutes, as amended by this act.

(B) Each health carrier shall monitor the timeliness and appropriateness of payments made by its intermediary to participating providers and of health care services received by covered persons.

(6) In the event of the intermediary's insolvency, a health carrier shall have the right to require the assignment to the health carrier of the provisions of a participating provider's contract that address such participating provider's obligation to provide covered benefits. If a health carrier requires such assignment, such health carrier shall remain obligated to pay the participating provider for providing covered benefits under the same terms and conditions as the intermediary prior to the insolvency.

(e) The commissioner shall not act to arbitrate, mediate or settle (1) disputes regarding a health carrier's decision not to include a health care provider or facility in such health carrier's network or network plan, or (2) any other dispute between a health carrier, such health

carrier's intermediary or one or more participating providers, that arises under or by reason of a participating provider contract or the termination of such contract.

Sec. 3. (NEW) (*Effective January 1, 2017*) (a) As used in this section: (1) "Covered person", "facility" and "health carrier" have the same meanings as provided in section 38a-591a of the general statutes, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa of the general statutes, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f of the general statutes, as amended by this act.

(b) (1) Each health carrier shall post on its Internet web site a current and accurate participating provider directory, updated at least monthly, for each of its network plans. The health carrier shall ensure that consumers are able to view all of the current participating providers for a network plan through a clearly identifiable link or tab on such health carrier's Internet web site, without being required to create or access an account or enter a policy or contract number.

(2) Each health carrier shall provide, upon request from a covered person or a covered person's representative, a print copy of such directory or of requested information from such directory.

(c) (1) A health carrier shall include in each such electronic or print directory the following information in plain language: (A) A description of the criteria the health carrier used to build its network; (B) if applicable, a description of the criteria the health carrier used to tier its participating providers; (C) if applicable, a description of how the health carrier designates the different participating provider tiers or levels in the network and identifies, for each specific participating provider, in which tier each is placed, such as by name, symbols or grouping, to allow a consumer to be able to identify the participating provider tiers; and (D) if applicable, a statement that authorization or referral may be required to access some participating providers.

(2) Each such directory shall also include a customer service electronic mail address and telephone number or an Internet web site address that covered persons or consumers may use to notify the health carrier of any inaccurate participating provider information in such directory.

(3) Each health carrier shall make it clear for each such electronic or print directory which directory applies to which network plan, such as by including the specific name of the network plan as marketed and issued in this state.

(4) Each such electronic or print directory shall accommodate the communication needs of individuals with disabilities and include an Internet web site address or information regarding available assistance for individuals with limited English proficiency.

(d) (1) The health carrier shall make available through an electronic participating provider directory, for each of its network plans, the following information in a searchable format:

(A) For health care providers, (i) the health care provider's name, gender, participating office location or locations, specialty, if applicable, medical group affiliations, if any, facility affiliations, if applicable, participating facility affiliations, if applicable, (ii) any languages other than English spoken by such health care provider, and (iii) whether such health care provider is accepting new patients;

(B) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer, the participating hospital location and the hospital's accreditation status; and

(C) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at the facility and the participating facility location or locations.

(2) In addition to the information required under subdivision (1) of this subsection, the health carrier shall make available through the electronic directory specified under subdivision (1) of this subsection,

for each of its network plans, the following information:

(A) For health care providers, the health care provider's contact information, board certification and any languages other than English spoken by clinical staff, if applicable;

(B) For hospitals, the hospital's telephone number; and

(C) For facilities other than hospitals, the facility's telephone number.

(3) (A) Each health carrier shall make available in print, upon request, the following participating provider directory information for the applicable network plan:

(i) For health care providers, (I) the health care provider's name, contact information, specialty, if applicable and participating office location or locations, (II) any languages other than English spoken by such health care provider, and (III) whether such health care provider is accepting new patients;

(ii) For hospitals, the hospital name, the hospital type, such as acute, rehabilitation, children's or cancer and the participating hospital location and telephone number; and

(iii) For facilities other than hospitals, by type, the facility name, the facility type, the types of health care services performed at such facility and the participating facility location or locations and telephone number or numbers.

(B) Each health carrier shall include with the print directory information under subparagraph (A) of this subdivision and in the print participating provider directory under subdivision (2) of subsection (a) of this section a statement that the information provided or included is accurate as of the date of printing, that covered persons or prospective covered persons should consult the health carrier's electronic participating provider directory on such health carrier's Internet web site and that covered persons may call the telephone

number on such covered person's insurance card for more information.

(4) For the information required to be included in a participating provider directory pursuant to subdivisions (1) and (2) of this subsection, each health carrier shall make available through such directory the sources of such information and any limitations on such information, if applicable.

(e) Each health carrier shall periodically audit at least a reasonable sample size of its participating provider directories for accuracy and retain documentation of such audit to be made available to the commissioner upon request.

Sec. 4. Section 19a-904a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) On and after January 1, 2016, each health care provider shall, prior to any scheduled admission, procedure or service, for nonemergency care, determine whether the patient is covered under a health insurance policy. If the patient is determined not to have health insurance coverage or the patient's health care provider is out-of-network, such health care provider shall notify the patient, in writing, electronically or by mail, (1) of the charges for the admission, procedure or service, (2) that such patient may be charged, and is responsible for payment for unforeseen services that may arise out of the proposed admission, procedure or service, and (3) if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply. Nothing in this subsection shall prevent a health care provider from charging a patient for such unforeseen services.

(b) Each health care provider and health carrier shall ensure that any notice, billing statement or explanation of benefits submitted to a patient or insured is written in language that is understandable to an average reader.

(c) No health care provider shall collect or attempt to collect from an insured patient any money owed to such health care provider by such patient's health carrier.

Sec. 5. Subsection (a) of section 38a-477e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) On and after July 1, 2016, each health carrier, as defined in section 38a-1084a, shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) **[**a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages spoken by health care providers**]** a directory of participating providers, as defined in section 38a-472f, as amended by this act, in accordance with the provisions of section 38a-472f, as amended by this act; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 6. Section 38a-478d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

For any contract delivered, issued for delivery, renewed, amended or continued in this state, each managed care organization shall:

(1) **[**Provide at least annually to each enrollee a listing of all providers available under the provisions of the enrollee's enrollment

agreement, in writing or through the Internet at the option of the enrollee;

(2) Include**]** Provide at least annually to each enrollee a provider directory that conforms to the requirements of section 3 of this act. Such directory shall include, under a separate category or heading, participating advanced practice registered nurses; **[**in the listing of providers specified under subdivision (1) of this section;**]** and

[(3)**]** (2) For a managed care plan that requires the selection of a primary care provider:

(A) Allow an enrollee to designate a participating, in-network physician or a participating, in-network advanced practice registered nurse as such enrollee's primary care provider; and

(B) Provide notification **[**, as soon as possible**]** in accordance with subsection (g) of section 38a-472f, as amended by this act, to each such enrollee upon the termination or withdrawal of the enrollee's primary care provider.

Sec. 7. Section 38a-478h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) Each contract delivered, issued for delivery, renewed, amended or continued in this state between a managed care organization and a participating provider shall **[**require the provider to give at least sixty days' advance written notice to the managed care organization and shall require the managed care organization to give at least sixty days' advance written notice to the provider in order to withdraw from or terminate the agreement**]** conform to the requirements of section 2 of this act and shall include notice provisions for the removal or departure of such provider in accordance with subsection (g) of section 38a-472f, as amended by this act.

[(b) The provisions of this section shall not apply: (1) When lack of such notice is necessary for the health or safety of the enrollees; (2) when a provider has entered into a contract with a managed care

organization that is found to be based on fraud or material misrepresentation; or (3) when a provider engages in any fraudulent activity related to the terms of his contract with the managed care organization.**]**

[(c)**]** (b) No managed care organization shall take or threaten to take any action against any provider in retaliation for such provider's assistance to an enrollee under the provisions of section 38a-591g.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-472f
Sec. 2	*January 1, 2017*	New section
Sec. 3	*January 1, 2017*	New section
Sec. 4	*January 1, 2017*	19a-904a
Sec. 5	*January 1, 2017*	38a-477e(a)
Sec. 6	*January 1, 2017*	38a-478d
Sec. 7	*January 1, 2017*	38a-478h

Statement of Legislative Commissioners:
In Section 1(a)(1)(A) and (B), "a person" was changed to "an individual" for accuracy; Section 1(a)(1)(C) was rearranged for clarity; Section 1(c)(1)(B) was redrafted for consistency with standard drafting conventions; in Section 1(c)(2), the designators were changed for consistency with standard drafting conventions; in Section 1(i)(1), "title 38a" was changed to "this title" for accuracy; and in Section 2(b)(2), "subdivision (2)" was changed to "subdivision (1)" for accuracy.

INS *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill requires the Insurance Department to: (1) review and determine the sufficiency of a health carrier's provider network subject to specified criteria, and (2) to adopt regulations implementing the bill's provisions for a health carrier's provider networks, contracts and directories. This does not result in a fiscal impact to the Department as it has the expertise necessary to undertake these provisions.

The bill does not result in a cost to the state employee and retiree health plan as the state plan currently has a network which complies with the requirements of the bill. The bill is not anticipated to result in a fiscal impact to municipal health plans.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 433

AN ACT CONCERNING STANDARDS AND REQUIREMENTS FOR HEALTH CARRIERS' PROVIDER NETWORKS AND CONTRACTS BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS.

SUMMARY:

This bill requires health carriers (e.g., insurers and HMOs) to establish and maintain adequate provider networks to assure that all covered benefits are accessible to covered individuals without unreasonable travel or delay. Carriers must ensure that emergency services are available at all times. Under current law, networks must be consistent with (1) the National Committee for Quality Assurance's (NCQA) network adequacy requirements or (2) URAC's provider network access and availability standards. (URAC, formerly known as the Utilization Review Accreditation Commission, and NCQA are nonprofit health quality organizations).

The bill requires the insurance commissioner to review and determine the sufficiency of a health carrier's provider network, subject to specified criteria. Additionally, it requires a carrier to provide benefits at the in-network level of coverage when a nonparticipating provider performs covered services for a covered individual if a participating provider is not available in the network.

The bill requires carriers to (1) make a good faith effort to give written notice to a participating provider's patients when the provider leaves the network and (2) provide for the continuity of care for patients in an active course of treatment with the provider. It also establishes standards for contracts between a health carrier and its participating providers and requires carriers to maintain a current and accurate provider directory on its website that it updates at least

monthly.

The bill authorizes the commissioner to adopt regulations implementing the bill's provisions for a health carrier's provider networks, contracts, and directories.

Lastly, the bill prohibits a provider from collecting or attempting to collect from an insured patient any money the patient's health carrier owes to the provider. By law, it is an unfair trade practice for a health care provider to request payment from a health care plan enrollee, except for a copayment, deductible, coinsurance, or other out-of-pocket expense, for covered health care services (CGS § 20-7f, as amended by § 11 of PA 15-146).

EFFECTIVE DATE: January 1, 2017

NETWORK ADEQUACY REQUIREMENTS

Network, Access Plan, and Material Changes Must be Filed

The bill requires each health carrier, beginning January 1, 2017, to file with the insurance commissioner each existing network and access plan (described below). For each new network a carrier plans to offer after that date, the carrier must file the new network and access plan with the commissioner within 30 days before offering the network.

A carrier must notify the commissioner of any material change to a network within 15 days after the change and must file an update to the network within 30 days after the change. The bill defines a "material change" as (1) a change of 25% or more in the participating providers in the network or (2) any change that makes the network noncompliant with the network adequacy requirements that causes the network to be significantly different from what a covered individual initially purchased.

Sufficiency of Network

The bill requires the insurance commissioner to determine the sufficiency of a health carrier's network. In determining sufficiency, she may refer to any reasonable criteria, including the:

1. ratio of participating providers to covered individuals by specialty;

2. ratio of primary care providers to covered individuals;

3. geographic accessibility of participating providers;

4. geographic variation and dispersion of the state's population;

5. wait times for appointments with participating providers;

6. participating providers' hours of operation;

7. network's ability to meet covered individuals' needs;

8. availability of other health care delivery system options, including telemedicine, centers of excellence, and mobile clinics;

9. volume of technological and specialty care services available to those who require them;

10. extent to which participating providers are accepting new patients;

11. degree to which participating providers are authorized to admit patients to participating hospitals and hospital-based providers; and

12. regionalization of specialty care.

Access Plan

A health carrier's access plan must be in a form the commissioner prescribes and must include:

1. the carrier's network, including how telemedicine, telehealth, or other technology is used to meet network access standards;

2. the carrier's procedures for making and authorizing referrals within and outside its network;

3. the carrier's procedures for monitoring and assuring on an ongoing basis the sufficiency of its network;

4. factors used to build the network, including criteria used to select and tier health care providers and facilities;

5. the carrier's efforts to address the needs of all covered persons and to include various types of essential community providers (those serving low-income, medically underserved people) in its network;

6. methods for assessing the health care needs of covered individuals and their satisfaction with the health care services provided;

7. how the carrier informs covered individuals of covered benefits, including grievance and appeal processes, how to choose or change participating providers, and the health carrier's process for updating its participating provider directories;

8. how covered individuals may change who they designate as a primary care provider;

9. the carrier's way of ensuring coordination and continuity of care for covered individuals, including in the event of (a) a contract termination between the carrier and a participating provider or (b) the health carrier's insolvency or other inability to continue operations;

10. the process for monitoring access to specialist services (i.e., emergency room care, anesthesiology, radiology, hospitalist care, and pathology and laboratory services) at the carrier's participating hospitals;

11. the carrier’s efforts to ensure that its participating providers meet available and appropriate quality of care standards and health outcomes;

12. the carrier's accreditation by (a) NCQA, affirming that the carrier meets NCQA's network adequacy requirements or (b) URAC, affirming that the carrier meets URAC's provider network access and availability standards; and

13. any other information the commissioner requires to determine the carrier's compliance with the bill.

The bill requires a health carrier to post each access plan on its website and make it available at its Connecticut business location and to anyone upon request. But the carrier may exclude from a publicly available access plan any information that it deems proprietary. A carrier may also ask the commissioner not to disclose proprietary information under the Freedom of Information Act.

Carrier Requirements

The bill requires a health carrier to:

1. maintain adequate arrangements with providers to assure that its covered individuals have reasonable access to participating providers near their homes or jobs;

2. monitor the ability, clinical capacity, and legal authority of its participating providers to provide all covered benefits to its covered individuals;

3. establish and maintain procedures for notifying a participating provider of the specific covered health care services for which he or she is responsible;

4. ensure that participating providers provide covered benefits to all covered individuals whether the person is enrolled as a private purchaser or as a participant in a publicly financed health care program;

5. notify participating providers of their obligations to (a) collect coinsurance, deductibles, or copayments from covered individuals and (b) notify individuals of their financial

obligations for noncovered benefits;

6. establish and maintain procedures by which a participating provider may determine in a timely manner when benefits are provided whether an individual is covered or is within a grace period for paying premium during which the carrier may hold a claim for health care services pending receipt of premium payment;

7. timely notify a health care provider or facility of the provider's or facility's network participation status;

8. notify participating providers of their responsibilities with respect to the carrier's administrative policies and programs, including payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance and appeals processes, reporting if the practice is not accepting new patients, confidentiality requirements, and obtaining necessary referrals to nonparticipating providers; and

9. establish and maintain procedures for resolving disputes between the carrier and a participating provider.

Carrier Prohibitions

The bill prohibits a health carrier from:

1. offering or providing an inducement to a participating provider to encourage the provider to provide less than medically necessary health care services to a covered individual;

2. prohibiting a participating provider from discussing any specific treatment option with covered individuals or advocating on behalf of covered individuals during utilization review or grievance and appeals processes; or

3. penalizing a participating provider because the provider reports in good faith to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare.

Selecting and Tiering Participating Providers

The bill requires a health carrier to develop standards for selecting and tiering participating providers and provider specialties. The carrier must make the standards available to the (1) insurance commissioner for her review and (2) public in plain language. Under the bill, a "tiered network" is a network of participating providers that identifies and groups health care providers and facilities into specific groups for which different reimbursement, cost-sharing, or access requirements apply for the same health care services.

Under the bill, a carrier cannot establish standards that would:

1. allow the carrier to discriminate against high-risk populations by excluding or tiering providers located in a geographic area that presents higher-than-average claims, losses, or health care service utilization;

2. exclude providers because they treat or specialize in treating populations that present higher-than-average claims, losses, or health care service utilization; or

3. allow the carrier to discriminate against a provider acting within the scope of his or her license or certification.

The bill specifies that it does not require a carrier to contract with every provider or facility willing to abide by its participation terms. It also does not require a carrier, its intermediaries, or contracted provider networks to (1) employ specific providers or (2) contract with more providers than are needed to maintain a sufficient network.

Coverage at In-Network Level of Benefits

Under the bill, a health carrier generally must provide benefits at the in-network level of coverage when a nonparticipating provider performs covered services for a covered individual if a participating provider is not available in the network. Specifically, a carrier must establish and maintain a process that ensures a covered individual receives covered benefits at the in-network level of benefits and cost

sharing from a nonparticipating provider when the carrier's network is either not sufficient or sufficient but does not have a (1) type of participating provider needed to provide the covered benefit or (2) participating provider available without unreasonable travel or delay.

A carrier must disclose to a covered individual how to request a covered benefit from a nonparticipating provider at the in-network level of benefits when the individual is diagnosed with a condition or disease that requires specialty care and the carrier (1) does not have a participating provider of the required specialty with the training and expertise to treat the person or (2) cannot provide reasonable access to such a participating provider without unreasonable travel or delay.

The carrier must respond to a request in a timely fashion appropriate for the individual's condition but no longer than allowed under the law for an external review. It must treat the health care service as being performed in-network, including counting the individual's cost sharing toward the out-of-pocket maximum limit applicable to in-network services.

The carrier must document all such requests and provide the documentation to the commissioner upon request.

The bill prohibits a carrier from using this process as a substitute for maintaining an adequate network. It also prohibits a covered individual from using the process to circumvent using covered benefits available through the carrier's network.

The bill specifies that it does not affect the rights or remedies available under state or federal law relating to grievances and appeals.

When a Participating Provider Leaves the Network

The bill, as under existing law, requires that a health carrier and participating provider provide each other at least 60 days' notice before a carrier removes the provider from the network or the provider leaves the network.

Under the bill, a participating provider who is removed from or leaves the network must give the carrier a list of his or her patients covered under a network plan of the carrier. The carrier must make a good faith effort, within 30 days after providing or receiving a notice of termination, to give written notice of the provider's departure to each covered patient being treated on a regular basis and, if the provider is a primary care provider (PCP), each covered patient of the PCP.

Continuity of Care

The bill requires a health carrier to establish and maintain continuity of care procedures to transition a covered individual who is in an active course of treatment with a participating provider who is removed from or leaves the carrier's network to another participating provider.

Under the bill, an active course of treatment is care provided during the second or third trimester of pregnancy or an ongoing course of treatment for a condition that (1) is life-threatening; (2) is acute; or (3) will worsen or interfere with anticipated outcomes if the treatment is discontinued, according to the treating provider. Further, covered individuals treated on a regular basis are deemed to be in an active course of treatment.

In addition to requiring the carrier to provide notice that a provider is leaving the network (as described above), the bill requires the carrier to also give the covered individual a list of available participating providers of the same type in the same geographic area and the procedures for requesting continuity of care.

A carrier's continuity of care procedures must provide that:

1. a covered individual or his or her authorized representative may request continuity of care;

2. a continuity of care request for a covered individual undergoing an active course of treatment must be reviewed by the carrier's medical director after consulting with the treating provider, as

long as the treating provider is not leaving the network for cause; and

3. the continuity of care period for an individual in the second or third trimester of pregnancy must extend through the postpartum period.

Under the bill, the continuity of care period for someone undergoing an active course of treatment must last until the earliest of:

1. the end of the course of treatment;

2. 90 days after the treating provider leaves the network, unless the medical director decides a longer period is needed;

3. the date the individual's care is transitioned to another participating provider;

4. the date benefit limitations under the plan are met or exceeded; or

5. the date the carrier determines the care is no longer medically necessary.

The bill specifies that a carrier can grant a continuity of care period only if the treating provider leaving the network agrees in writing to (1) accept the same payment and terms as when he or she was participating in the network and (2) not seek any payment from a covered individual for any amount he or she would not have been responsible for if the provider was still in the network.

PROVIDER CONTRACT REQUIREMENTS

Required Provisions

The bill specifies certain provisions that contracts between a health carrier and a participating provider ("provider contract") must contain. The requirements apply to contracts entered into, renewed, or amended on or after January 1, 2017.

The bill requires a provider contract to include a specified hold harmless provision that protects covered individuals from being billed for more than they are required to pay for services covered under the plan. It also requires a provider contract to include a provision that, if a carrier becomes insolvent or operations cease, the participating provider must continue delivering covered health care services to covered individuals until the date the individual's coverage under the plan ends or the provider contract would have ended had the carrier remained in operation, whichever is earlier.

Under the bill, a provider contract must require a participating provider to make health records available to state and federal authorities investigating grievances or assessing the quality of care provided to covered individuals. The contract must require the provider to comply with applicable state and federal laws on the confidentiality of health records and an individual's rights to view, obtain copies of, or amend his or her health records.

In addition, the bill requires a provider contract to define what "timely notice" and "material change" mean for purposes of complying with a requirement that the carrier give providers timely notice of any material changes to the contract.

The bill specifies that a provider contract's terms must:

1. be construed in favor of covered individuals;

2. survive the termination of the contract; and

3. supersede any agreement between a provider and a covered individual, or his or her authorized representative, that is contrary to the bill.

Prohibitions

Under the bill, a provider contract cannot conflict with the provisions contained in the carrier's network plan or the bill's network adequacy, provider contract, and provider directory requirements.

The bill prohibits carriers and participating providers that are parties to a provider contract from assigning or delegating any right or responsibility under the contract without the other party's written consent.

Required Disclosure

The bill requires a carrier or its intermediary, when a provider contract is signed, to disclose to the provider all provisions and other documents incorporated by reference in the contract. An "intermediary" is a person or entity authorized to negotiate and execute provider contracts with carriers on behalf of providers.

Contracts between Carriers and Intermediaries

The bill requires contracts between a health carrier and an intermediary to comply with certain provisions. The requirements apply to contracts entered into, renewed, or amended on or after January 1, 2017.

Under the bill, a carrier cannot delegate to an intermediary the carrier's responsibilities to monitor the offering of covered benefits to covered individuals. To the extent a carrier delegates other responsibilities to an intermediary, the carrier remains responsible for the intermediary's compliance with the bill's provider contract requirements.

The bill gives the carrier the right to approve or disapprove a provider's or facility's participation status in the carrier's network, whether its own or a subcontracted network. It requires the carrier to keep at its principal place of business in Connecticut copies of all intermediary subcontracts or at least have access to all such contracts. Under the bill, a carrier has the right, upon 20 days' prior written request, to make copies of all such subcontracts for regulatory review purposes.

The bill requires an intermediary, if applicable, to give a carrier documentation of the health care services used and claims paid. An intermediary must also keep at its principal place of business in

Connecticut, for regulatory review purposes, books, records, financial information, and documentation of health care services covered individuals received, for as long as the insurance commissioner prescribes. An intermediary must allow the commissioner access to such information as needed for her to determine compliance with the bill's network adequacy and provider contract requirements.

Under the bill, a health carrier must monitor the timeliness and appropriateness of (1) payments an intermediary makes to participating providers and (2) health care services covered individuals receive.

If an intermediary becomes insolvent, the bill gives a health carrier the right to require the intermediary to assign to it the provider contract provisions that address a provider's obligation to provide covered benefits. If such assignment is required, the carrier remains obligated to pay the participating provider under the same terms and conditions as applied before the insolvency.

Disputes

Under the bill, the insurance commissioner cannot arbitrate, mediate, or settle disputes (1) over a carrier's decision not to include a provider or facility in its network or (2) between a carrier, an intermediary, or a participating provider that arise under a provider contract or its termination.

PROVIDER DIRECTORY REQUIREMENTS

Accurate Directories Required

The bill requires a health carrier to post on its website a current and accurate directory of its participating providers ("provider directory") for each of its network plans. The carrier must update the directories at least monthly. Consumers must be able to view the directories on a carrier's website without having to create or access an account or enter a policy or contract number. A carrier must provide a printed copy of a directory or information from it upon request of a covered individual or his or her authorized representative.

Contents of a Directory

The bill requires a carrier to include a plain language description of the following in each provider directory:

1. the criteria the carrier used to build its network and, if applicable, tier its participating providers;

2. how the carrier designates the different tiers in the network and in which tier each participating provider is placed using a name, symbol, or grouping that allows the consumer to identify the tiers; and

3. if applicable, that an authorization or referral may be required to access some participating providers.

A provider directory must also include a customer service email address and telephone number or a website address that consumers and covered individuals can use to inform the carrier of inaccuracies in the provider directory.

A carrier must clearly identify which provider directory applies to which network plan. And each directory must accommodate individuals with disabilities and individuals with limited English proficiency.

Online Directories. For each participating provider, a carrier's online provider directory must include the provider's name, gender, specialty, board certification, participating office locations, medical group affiliations, facility affiliations, participating facility affiliations, languages the provider and staff speak other than English, contact information, and if the provider is accepting new patients.

For each participating hospital, the online directory must include the name and the type of hospital (e.g., acute, rehabilitation, children's, cancer), the participating location, the hospital's accreditation status, and its telephone number.

For each participating facility other than a hospital, the online

directory must include the facility name, the types of health care services performed there, the participating locations, and its telephone number.

Online directories must also make available the sources of, and any limitations on, its information.

Print Directories. A carrier's printed provider directories must be available upon request and must include the following information:

1. for a participating provider, the provider's name, contact information, specialty, participating office locations, languages spoken other than English, and if he or she is accepting new patients;

2. for a participating hospital, the name and the type of hospital, participating location, and telephone number; and

3. for a participating facility other than a hospital, by type, the name and the type of facility, type of health care services performed there, participating locations, and telephone number.

A carrier must include a statement in a printed directory that the information is accurate as of the print date and the consumer should consult the carrier's online provider directory or call the carrier for more information.

Audit Required

The bill requires a carrier to periodically audit a reasonable sample size of its provider directories for accuracy. It must keep the audit documentation and provide it to the insurance commissioner upon her request.

ENFORCEMENT

Under the bill, if the insurance commissioner determines that a health carrier has not complied with the bill's network adequacy, provider contract, or provider directory requirements, the health carrier must implement a corrective action plan as directed by the

commissioner. The commissioner may take any action authorized under the state's insurance laws to bring a carrier into compliance. By law, the commissioner may fine a carrier up to $15,000 per violation (CGS § 38a-2).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 18 Nay 0 (03/17/2016)